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What About the Patient? The Effects of Mergers and Acquisitions in the Hospital Industry on Patient Care

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Abstract

The hospital industry and market for healthcare have grown increasingly complex over the last decade. When the Affordable Care Act (ACA) was enacted in 2010, hospital mergers and consolidations were already on the rise but have since increased substantially. While new, improved efficiencies and integration are often crucial for hospitals and clinics to run successfully, making too many unnecessary changes can negatively affect patient care. This study addresses the negative implications of increased market concentration in the hospital industry, discusses how the ACA has driven these incentives, and provides examples of what is occurring in Washington State. Large mergers and continuing consolidation have driven up costs and negatively impacted patient care. There are additional concerns stemming from increased market concentration, including some that could be better understood if more quantitative data was available. In light of these mergers, it is clear that improved costs, quality, and access for patients need to continue to be closely monitored priorities.

The US hospital industry has grown increasingly complex over the last century. From health systems to Health Maintenance Organizations (HMOs) and Accountable Care Organizations (ACOs), the industry is redefined constantly. In the mid-1700s, hospitals were sanctuaries for the poor and resting places for a person's final days, eventually becoming places to recover from illness (Wall, n.d.). Primarily funded by philanthropies, religious organizations, and generous donations, hospitals ensured that those in need of care were not turned away; hospitals tended to be charitable work done in the name of God (Henderson, 2018, p. 307). Caring for an individual was two-fold, and often meant providing "spiritual sustenance" (Wall, n.d.). Most recently referred to as "charity care," this element is still a compulsory part of a hospital's function even if it is not as present in modern times. Despite charity care still being compulsory, the majority of health services operate primarily from a business perspective, fundamentally because of the unsustainable costs facing the US healthcare system (Henderson, 2018, p. 307). In a recent study of the nation's ten most profitable hospitals, seven of them were nonprofit (Bai & Anderson, 2016, p. 889-897). A common misconception is that nonprofit hospitals do not need to prioritize their revenue stream. Being deemed nonprofit is simply for tax purposes. Revenues matter regardless of tax status and must break even with costs for any type of hospital to remain operational, just like any business. Regardless of whether an institution is for-profit or nonprofit, scarcity of resources is an issue.

National health expenditures have continued to climb, increasing by 3.9% from 2016 to 2017 and accounting for 17.9% of total gross domestic product (GDP). That amounts to \$10,739 per person (NHE Fact Sheet, 2017). With an overnight hospital stay costing patients, on average, \$1,013 per day after insurance, many question why costs are continually on the rise (Adrion, 2016, p. 1325). There are innumerable culprits suspected to be contributing factors of surging medical costs, such as the complexity of private insurance and its propensity to dictate hospital care, the rising costs of prescription drugs, and expensive new technology. However, one cause that has been gaining more critical attention in recent years is the intensification of hospital mergers and acquisitions. While mergers can improve efficiencies due to two entities coming together to be one, these efficiencies can occasionally be detrimental. My study investigates how the purported efficiencies of hospital mergers might affect the patient: are they resulting in improved quality of care for patients? Are personal, out-of-pocket costs increasing or decreasing? I discuss the incentives and benefits horizontal integration can bring to hospitals and why the Affordable Care Act (ACA) contributed further incentives, highlighting recent mergers within the Greater Seattle area. I then examine the major concerns and potential problems this phenomenon causes.

The ACA was designed to promote interaction, integration, and coordination between physicians throughout hospitals and clinics alike (Kocher, DeParle, & Emanuel, 2010, p.

537). From an economic perspective, this vertical integration (integrating up through a clinic and hospital) makes sense: streamlining office practices and coordinating patient data can lead to more readily accessible information (Kocher et al., 2010, p. 537). Additionally, the implementation of electronic medical records (EMRs) allows information to transfer quickly and easily between clinics and hospitals. However, aside from small practices combining forces vertically, horizontal integration is also beginning to occur: already-large hospitals are merging with equally large or larger hospitals to become giant conglomerates. A report by Kaufman Hall, an Illinois consulting firm, showed that there were 115 hospital mergers in 2017 alone—the highest number in recent history and up 13% since 2016 (Kaufman Hall, 2017, p. 1).

According to Elizabeth Barker and other scholars, these horizontal mergers have generated some positive results that can be categorized into three distinct industry improvements: improved efficiency, improved access to care, and improved quality of care (Barker, 2017). Nevertheless, it is still too soon to determine the real impact mergers are having on consumers. The knowledge that increased market concentration can lead to price increases is concerning, prompting many to question whether these deals and the increased efficiency they claim to provide are really beneficial to patients.

It is important to note that consolidations and mergers are not identical in nature and can have different implications. A merger occurs when two or more corporations combine to form a single corporation where one company acquires all liabilities and assets. Although a consolidation can stem from a merger, the act of consolidating creates an entirely new enterprise composed of all liabilities and assets involved. The hospital sector has experienced both ventures, but mergers are more common because they do not require the development of a completely new entity. The process typically involves two hospitals coming together and taking on the name and characteristics of the larger entity while still incorporating some of the smaller entity's characteristics.

In 2006, the Robert Wood Johnson Foundation, the nation's largest health-centered philanthropy, conducted a study called the Synthesis Project. This study provided some substantial information about the impact these ventures are having on our health care system as a whole. They obtained and analyzed data concerning the increased concentration of hospitals in single markets, the cost of care after mergers and consolidations, and the quality of administered care. Their findings were updated in 2012 to further confirm the original report: an increase in hospital consolidation has, in fact, led to an increase in the cost of hospital care (Gaynor & Townsend, 2012, p. 1). They also found that in an already concentrated market, hospital mergers can drive prices up by more than 20% (p. 1). Even with these clear indicators that mergers are a contributing factor to price increases, the Federal Trade Commission (FTC) and Department of Justice (DOJ) have not yet seen reason to block any of these mergers.

While it is common for establishments to exit the market for healthcare, entry into the hospital industry in particular is not easy. Most states have specific guidelines and requirements, such as filing for a certificate of need and demonstrating that these community needs are not being addressed thus far. Along with these regulations, there are five main barriers to entry: large fixed-capital requirements, product differentiation (gaining trust of new consumers), switching costs (changing suppliers), economies of scale (based on hospital bed capacity), and access to physicians (Babate, J., n.d., p. 32-51). High fixed costs and economies of scale are two leading reasons many hospitals gravitate towards mergers. From an administrative perspective, merging allows for the hospitals' costs to be shared and resources to be allocated in various ways, resulting in increased efficiency. This is why the persistent pressure from the ACA for hospitals to expand technologically and provide the latest and greatest care has further accelerated consolidation (Bigger and better, 2011).

The Greater Seattle area has also experienced this national phenomenon, beginning with Providence Health & Services and Swedish Health & Services officially joining forces in 2012. Following close behind was UW Medicine and PeaceHealth, when they finalized a strategic alliance in 2013, and Providence Health & Services merged with Providence St. Joseph Health in July 2016. Most recently, in December 2017, Providence and Ascension Health announced discussion of a possible consolidation, only to see talks halted in March (Providence and Swedish, 2012). Providence is the largest healthcare provider in Washington with a total of 1,875 available beds (Washington State Department of Health). UW Medicine is the ACO, encompassing all of UW Medicine's various entities, including many clinics and hospitals alike. UW Medicine captures a large part of the market in the Seattle Metro area, and 63% of UW Medicine's revenue comes specifically from their hospitals, operating with 1,370 available beds in King County alone (UW Medicine Annual Financial Reports; Washington State Department of Health). According to a joint statement from the executives of Swedish and Providence, the merger would allow both organizations "to collaborate to better deliver health care to the region" (Ostrom, 2012). However, as market concentration increases, competition decreases, resulting in fewer options for patients and even less leverage to negotiate prices. Thus, the question remains: are these giant mergers negatively impacting the quality of care?

Dr. Susan Haas, Dr. William Berry, and CEO of Risk Management Foundation Mark Reynolds recently concluded a study attempting to determine exactly how patients are affected by massive mergers and acquisitions. They summarized their findings as three key areas of risk: new patient populations (adjusting to serve a population of patients that varied from the previous norm), unfamiliar infrastructure (needing to navigate a new facility in a short amount of time or being unfamiliar with equipment), and lastly, new settings for physicians (receiving little or no systematic orientation) (Haas, Berry, & Reynolds, 2018). These risks are introduced more frequently when hospitals expand and begin functioning more like

traditional businesses, focus increasingly on efficiencies and profits, and potentially forget elements that are key to their success as places of care. One can only increase efficient practices to the extent that the practice or service is actually improving. It is a classic case of diminishing marginal returns: at some point, each additional unit of efficiency is going to increase the overall service's efficiency less and less. Eventually, the patient could be hurt by the continued push to increase efficiency.

Furthermore, as hospital markets become increasingly concentrated, patients have less choice in where they can receive care. Researchers at Carnegie Mellon University's Heinz College explained that when there are four or fewer hospitals in a local market, admission prices can be up to 16% higher than in less-concentrated markets (Kacik, 2017). In some cases, markets for both health providers and insurers can be highly concentrated, leading to insurers having superior negotiating power (Fulton, Arnold, & Scheffler, 2018). While those insured might get a small break on a bill, the uninsured are severely impacted by increased price and decreased access. A combination of studies and stories compiled into an article by Health Finance, a publication of Healthcare Information and Management Systems Society, discusses the implications of hospitals in rural communities with a large uninsured population. When the majority of prospective patients can't afford treatment, the few available hospitals are forced to cut back on services, further limiting already sparse choice (Rovner, 2017). Rural areas are also less attractive to providers, adding another caveat to patient choice. When hospitals increase prices, insurance companies demand more reimbursement, which results in premium hikes for patients and further accelerates this perpetual cycle. With hospitals like Harborview Medical Center in Seattle, Washington (which operates on a 1% margin and primarily serves uninsured and low-income populations), this cycle presents a significant problem for both patient and care facility (Beason, 2014).

A final question, one I wish to explore further in the future, is how increased market concentration and mergers are adversely affecting particular services. One growing area of concern is that both male and female reproductive services could be negatively impacted as an increased number of nonprofit, typically Catholic-affiliated, hospitals merge with for-profit, public, or state hospitals. While there is no significant quantitative data to support these claims, there have been recent studies that warrant further investigation. The Ethical and Religious Directives for Catholic Healthcare Services, issued by the US Conference of Catholic Bishops (2009), specifically limit the reproductive health services that can be offered in a hospital of Catholic affiliation Elaine Hill and David Slusky reported that there has been a 22% growth rate of mergers between non-Catholic and Catholic hospitals; there were 120 mergers between 2001 and 2016 (Hill, Slusky, & Ginther, 2017, p. 1). With the majority of these hospitals being the only ones for miles in rural areas, the increased market concentration further limits patient choice, largely without patient knowledge. If a Catholic hospital happens to merge

with the only existing hospital, which happens to be public, this is the only option available to patients. This also connects to the aforementioned certificates of need: in order for a new hospital to enter into a community, they must provide proof that a new healthcare facility is necessary. Overbuilding of healthcare entities can lead to unnecessary, increased costs for the individual and community. Therefore, restricted access further restricts choice.

An international reproductive health journal, *Contraception*, recently published a study which found that “women with annual incomes under \$25,000 are less likely to realize their hospital is Catholic than women who make more than \$100,000 a year” (Littlefield, 2018). Oftentimes, people in rural communities in need of medical procedures, typically patients with lower incomes, do not have the resources or ability to browse for other options regarding provider and price point, significantly restricting their choice. Taking these statistics a step further, a study by Columbia Law School’s Public Rights/Private Conscience Project found that 19 out of the 33 states surveyed provided data showing that women of color were more likely to give birth in Catholic hospitals (Shepherd, Platt, Franke, & Boylan, 2017, p. 9). The study proceeds to discuss the racial disparities existing in healthcare, and how women of color are already disproportionately affected (p. 34). Unfortunately, rural or very densely populated areas often overlap with low-income communities and people of color who fall under the federal poverty line, and this statistic further limits access and choice of care. While more concrete evidence indicating the magnitude of this issue is quite limited as of now, it is essential to monitor how increased market concentration, specifically regarding Catholic hospitals, impacts these particular services and communities of people.

In addition to significantly high out-of-pocket patient costs, other factors such as potential restrictions based on religious affiliation, the limited choice of hospitals dependent upon location, and rising rates for the uninsured population all contribute to critical apprehensions surrounding proliferating hospital mergers and consolidations. While there are still more studies to be developed and research to be conducted, this study gives a glimpse into this complicated but crucial industry. The potential consequences of increased market power and concentration of hospitals could be incredibly detrimental if not contained soon. It’s difficult to compare prices across hospitals and achieve price transparency because each hospital has its own chargemaster. A chargemaster is an extensive list of all billable items and is a document few people even know how to read. However, as of January 1, 2019, hospitals will now be required to electronically publicize a chargemaster of basic services. In theory, this is a step in the right direction toward improving transparency in hospital pricing and, as a result, improving the quality of patient care (“CMS Finalizes Changes,” 2018). In the past, hospitals have been hesitant to provide certain information, but this can make it more difficult for a patient to determine the realities of the care they might be receiving, specifically in respect to its quality. The studies I reference suggest a significant impact of hospital mergers

on the healthcare system as a whole; the impact on patients, however, is still largely unknown, and these next few years will be revealing. While there are always two sides to every issue, and many positives that can come from improved efficiencies, specifically those encouraged by the ACA, the negatives also need to be addressed. As a society, we need to question how these market occurrences affect patient healthcare, and ask what can be done to maintain the very essence of medical care: serving those in need.

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